

Additional
Exhibits.

EXHIBIT 6DATE 3-18-09SB 174

March 14, 2009

TO: Montana State Legislature – House Business Committee

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RE: SB 174: An Act Creating the Professional Classification of Clinical Pharmacist Practitioner

Mr. Chairman, Ladies and Gentlemen of the House Business Committee:

Thank you for your service to the good people of the State of Montana, the health and welfare of which are the reasons that I write.

My name is Vince Colucci. I am an Associate Professor, Department of Pharmacy Practice in the Skaggs School of Pharmacy at The University of Montana. I have practiced pharmacy in the state of Montana for 28 years. Currently, as clinical faculty from UM, I have a clinical practice site at The Western Montana Clinic, PC (Missoula), where I work with physicians to improve patient care through improved DRUG THERAPY. I co-manage an anticoagulation clinic and I am a component of a team-based approach heart failure clinic with the International Heart Institute. My work at these sites is subsidized by the Pharmacy Program at the University (this allows us to put pharmacy students in these sites as part of their formal clinical training).

Please allow me to offer argument IN FAVOR of SB174, which would allow for the establishment of an ADVANCED PHARMACIST PRACTITIONER.

The essence of this legislation is to establish a mechanism whereby clinical pharmacists can be recognized as providers of patient care and can be reimbursed for these patient care services. The failure of health care systems, such as Medicare, to include clinical pharmacists among its list of providers is costing the United States health care system billions of dollars annually and contributing to hundreds of thousands of strokes, heart attacks, and deaths each year. As an example, one recent report found that the absence of clinical pharmacy services for hospitalized Medicare patients requiring anticoagulation (i.e., blood thinners like Coumadin or heparin) cost more than 60,000 units of blood, \$3 billion in additional hospital charges, and more than 25,000 avoidable deaths annually.¹ It should be recognized that even more patient harm and waste occurs in non-Medicare patients and in the ambulatory (non-hospitalized) population. Pharmacists are not involved in this Medication Therapy Management (MTM) simply because they cannot be reimbursed for their clinical expertise as they are not recognized as providers of health care by the CMS and other 3rd-party payers. This bill differentiates between a dispensing pharmacist and a clinical pharmacist, challenging the latter to enhance and improve their skills for patient care. Is this an investment in your clinical pharmacist? Yes, but a review of 104 studies by Schumock et al² revealed that 90% of the economic evaluations found a positive financial benefit for a variety of clinical pharmacy services and that, on average, for every one dollar invested in clinical pharmacy services, \$16.70 was saved in terms of adverse drug reactions, less hospitalizations, drug side effects, overdosing or underdosing, and Emergency Dept. visits.

Below are a few more informative bullets supporting my argument:

- In 2002, The Medicare Payment Advisory Committee to Congress (MEDPAC) recognized Non-physician clinicians, more specifically clinical pharmacists, as relevant and important team members for patient care regards to Medication Therapy Management (MTM). The use of collaborative drug therapy management agreements (CDTM) was suggested as the means to create collegial and supervisor relationships associated with the MTM (Physicians \longleftrightarrow Pharmacists)
- Recent recommendations and reports from MEDPAC (June 2008) arguing for a MEDICAL HOME model of health care reform would be similarly supportive of pharmacists roles in patient care and MTM.

- While MT law has a CDTM statute in existence, the CDTM is but a tool. Additionally and more importantly, pharmacists are not recognized for cognitive or clinical services (by the CMS or most other third part payers) regarding MTM and are not eligible for reimbursement. Thus much of the needed MTM does not occur and patient care is compromised.

Therefore to 1) enhance the patient care 2) to differentiate patient care MTM services and the CLINICAL PHARMACIST from distribution or dispensing pharmacist, and 3) to ensure that this clinical pharmacist is competent and possesses expertise with regard to MTM, the legislation is offered. We think this is consistent with the MEDPAC recommendations and positions the CLINICAL PHARMACIST in a more responsible, challenging, accountable role and may help the CMS and other payers recognize CLINICAL PHARMACISTS as PROVIDERS of patient care and eligible for reimbursement for these patient care services. This has the full support of the MT Board of Medical Examiners by unanimous resolution.

- Opposition would suggest this would lead to pharmacists "practicing medicine", however, this legislation DOES NOT, in any way shape or form allow for individual pharmacist practitioners to exist, rather, it allows for CLINICAL PHARMACISTS with proper credentialing, training, and expertise to engage in and perform MTM and monitoring under the auspices of a physician or a group of physicians via CDTM (in other words...protocols). They would be working collaboratively with physicians and as physician extenders and hopefully recognized as patient care providers by the CMS and by other payers and health care plans. It is aimed at improving the drug-therapy aspect of patient care. Notably, the Congress-sponsored Institute of Medicine study of Preventable Drug Errors and Adverse Drug Events³ in hospitals identified in two separate reports (2000, 2006) over 100,000 preventable drug errors occur in hospitals alone every year with >7000 deaths...attributable to drugs or drug errors (This would be the equivalent of a jumbo jet liner crashing once weekly for a year killing all aboard)

- We think adding these skill and restrictive criteria to existing statute ensures the integrity, quality, and competency of the pharmacy profession and the individuals practicing within this realm. This increased skill level is a direct challenge to the pharmacist and would come about through increased training and experience, more continuing education (CE) requirements, pharmaceutical specialty board certifications or other credentialing body recognition commensurate with disease state management (Diabetes-CDE, Anticoagulation).
This would be under the governance of the MT Board of Pharmacy in concurrence with the MT Board of Medical Examiners.
- We are not mandating that ALL pharmacists are required to have these "extra" credentials, but are allowing for a method for those that wish to collaborate or collegialize with physicians in extended patient care via MTM to gain that recognition.
- Specific criteria that will administer this legislation or define in detail the statute will be in Administrative Rule. Note that physicians (BME) will fulcrum the process.
- It should be noted that 2 states...NM and NC have already enacted similar legislation and are successful in creating programs and projects that have demonstrated improved patient care outcomes based on improved drug therapy.

Respectfully submitted



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References:

1. Bong CA, Raehl CI. Pharmacist-provided anticoagulation management in the United States hospitals: death rates, length of stay, Medicare charges, bleeding complications, and transfusion. *Pharmacotherapy* 2004;24:953-63
2. Schumock GT, Meek PD, Ploetz PA, Vermeulen LC. Economic evaluation of clinical pharmacy services 1988-1995. *Pharmacotherapy* 1996;16:1188-208
3. Institute of Medicine: Quality Chasm Series. Committee on identifying and Preventing Medication Errors (Aspden P, Wolcott J, Bootman JL, Cronenwett LR, Eds). 2006 Report to Congress. Executive Summary available at: <http://www.nap.edu/catalog/11623.html>